Destiny Internal Medicine
and Post Acute Care Services PC

Date: _____

Patient Registration Form

PLEASE PRINT

PATIENT NAME (LAST/FIRST/MIDDLE INITIAL)	ADDRESS Email:		
CITY/STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER_____

RACE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ AFRICAN AMERICAN/BLACK
☐ CAUCASIAN/WHITE ☐ HAWAIIAN/PACIFIC ISLANDER ☐ OTHER _____

ETHNICITY ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

PATIENT EMPLOYER NAME	JOB TITLE	WORK PHONE

EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ STUDENT ☐ SELF-EMPLOYED ☐ ACTIVE MILITARY

Primary Insurer/Responsible Party **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Other_____

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE	ADDRESS (STREET/CITY/STATE/ZIP)	PHONE

GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

SECONDARY INSURANCE	ADDRESS (STREET/CITY/STATE/ZIP)	PHONE

GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

FORMER OR PAST PRIMARY DOCTOR/FAMILY DOCTOR	PERSON WHO REFERRED YOU TO OUR PRACTICE	
NAME OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

PHARMACY INFORMATON

PHARMACY NAME	PHONE	FAX
ADDRESS (OR CROSS STREETS)	CITY/STATE/ZIP CODE	

Destiny Internal Medicine
and Post Acute Care Services PC

Date: _____

Patient Medical History Form

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

ALLERGIES

ALLERGEN	REACTION	ALLERGEN	REACTION

FAMILY HISTORY

	Alive	Deceased/Date	Cause of Death
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐Yes ☐No - Do you exercise? ☐ Daily ☐Weekly ☐Infrequently

☐Yes ☐No - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently

☐Yes ☐No - Caffeinated beverages? ☐ Daily ☐Weekly ☐Infrequently

☐Yes ☐No - Tobacco? ☐ Smoke packs per: day ☐ week ☐ month☐

☐Yes ☐No - Recreational drugs? ☐ Daily ☐Weekly ☐Infrequently

SURGICAL HISTORY

TYPE OF SURGERY	YEAR or DATE	DOCTOR	PHONE

Preventative

	YEAR or DATE	DOCTOR	PHONE
Pap Smear			
Mammogram			
Prostate Check			
Colonoscopy			
Eye Exam			
Dental Visit			

MEDICAL HISTORY

❑ NONE of the problems listed	❑ Coronary Artery Disease	❑ Hepatitis	❑ Pneumonia
❑ Allergies	❑ Depression	❑ High Cholesterol	❑ Prostate Condition
❑ Anemia	❑ Diabetes - Insulin	❑ High Blood Pressure	❑ Pulmonary Embolism
❑ Angina	❑ Diabetes – Non-Insulin	❑ Insomnia	❑ Seizure Disorders
❑ Anxiety	❑ Diverticulitis	❑ Irritable Bowel Syndrome	❑ Shortness of Breath
❑ Arthritis	❑ DVT or Blood Clots	❑ Kidney Disease	❑ Skin Conditions
❑ Asthma	❑ Fibromyalgia	❑ Liver Disease	❑ Sleep Apnea
❑ Atrial Fibrillation	❑ Gallbladder Disease	❑ Menopause	❑ Stroke
❑ Blood Disorders	❑ GERD	❑ Migraines/Headaches	❑ Thyroid Disorder
❑ Cancer (Enter type below)	❑ Glaucoma	❑ Neuropathy	❑ TIA/Mini Stroke
❑ Cerebrovascular Accident	❑ Gynecological Condition	❑ Osteoporosis	❑ Tremors
❑ Congestive Heart Failure	❑ Heart Disease	❑ Parkinson's Disease	❑ Urinary Tract Infections

Additional medical conditions:

MEDICATIONS Please include over the counter medications

PLEASE PRINT CLEARLY

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Destiny Internal Medicine
and Post Acute Care Services PC

Patient Financial Responsibility Agreement Form

	Initials
I understand that I will need to present my insurance and photo ID at each visit and that my copay is due at the time of Check-In.	
My insurance may require a deductible to be met before they start to pay for services rendered. I understand that Destiny Internal Medicine will bill my insurance first and then I will be responsible for any amount remaining.	
I understand that I am responsible for contacting my insurance to confirm that Destiny Internal Medicine is in-network with my insurance plan and will be required to pay for charges not paid by my insurance.	
I understand that I am responsible for contacting my insurance to confirm my insurance benefits such as checking for in-network laboratories, annual physical exam coverage, etc. and will be required to pay for charges not paid by my insurance.	
I understand that I am responsible for contacting my insurance to confirm if my insurance plan requires a referral to see a specialist and to request this referral from my doctor. I understand that referrals will only be given after my doctor has evaluated me and determined it necessary. I understand that I am responsible for charges denied by my insurance due to neglecting to request a referral.	
I understand that any balances remaining after my insurance company processes my bill from Destiny Internal Medicine will be my responsibility. I understand I will be given 90 days after my insurance processes my bill to pay the balance due on my account or it will be sent to collections which may result in termination of care from this clinic.	
Print Patient Name:	
Patient Signature: Date:	

1550 S POTOMAC ST. STE 110, AURORA, CO 80012
* PHONE: 720-324-4777 * FAX: 720-262-4788
WWW.DESTINYIMPC.COM

Destiny Internal Medicine

and Post Acute Care Services PC

Patient Privacy HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Destiny Internal Medicine and Post Acute Care Services PC (DIMPACS) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of DIMPACS PC.

I have also been informed of and given the right to review and secure a copy of the clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that DIMPACS PC reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but DIMPACS PC is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

DIMPACS PC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time by asking front office staff for CORHIO Opt-Out form.

Print Patient Name:	
Patient Signature:	Date:

1550 S POTOMAC ST. STE 110, AURORA, CO 80012
* PHONE: 720-324-4777 * FAX: 720-262-4788
WWW.DESTINYIMPC.COM

Destiny Internal Medicine
and Post Acute Care Services PC

Late and Missed Appointment Policy

We make every effort to give quality care to our patients in a timely manner. Missed appointments and late cancellations inconvenience other patients who need access to care.

- We require a 24 hour advanced notice in order to cancel your appointment. This enables our staff to schedule other patients in need of urgent medical care. You will be charged a $35 missed appointment fee if we are not notified within this time frame.
- Patients arriving 10 minutes late for their scheduled office visit may be asked to reschedule the appointment for another day.
- If you miss your initial (first) appointment with our office, we reserve the right to not reschedule you.
- Late and missed appointments will be noted on your file.
- After the 3rd occurrence of a late or missed appointment, this may result in a dismissal from our practice.

I have read and understand the Late and Missed Appointment Policy for Destiny Internal Medicine and Post Acute Care Services PC.

Print Patient Name:
Patient Signature: Date:

1550 S POTOMAC ST. STE 110, AURORA, CO 80012
* PHONE: 720-324-4777 * FAX: 720-262-4788
WWW.DESTINYIMPC.COM